

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-018592

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1368

STATE FILE NUMBER

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Rev. 4/591 40002 207

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Koch</u>		Length of stay in lb <u>33 days</u>	c. CITY OR TOWN <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) <u>Robert Koch Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5055 Arlington</u>
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>E.</u> Last <u>McFarland</u>		4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1963</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-26-86</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <u>76</u>
11a. FATHER'S NAME <u>James Sheridan</u>		11b. MOTHER'S MAIDEN NAME <u>Ellen Murphy</u>	11c. BIRTHPLACE (City and state or country) <u>St. Louis</u>
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>No</u>		12b. SOCIAL SECURITY NO.	12c. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. NAME OF DECEASED <u>James Sheridan</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Murphy</u>	13c. NAME OF HUSBAND OR WIFE <u>George McFarland</u>
14. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u>		14b. INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>20021</u> DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary tuberculosis</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
20c. TIME OF INJURY Hour <u>10:38</u> a.m. <u>10:38</u> p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>	
20g. COUNTY <u>Missouri</u>		20h. STATE <u>Missouri</u>	
21. I attended the deceased from <u>March 21, 63</u> to <u>4-24, 63</u> and last saw her/him alive on <u>April 24, 63</u> Death occurred at <u>10:38 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>Axel R. Brown, M.D.</u>	
22b. ADDRESS <u>Koch, Mo.</u>		22c. DATE SIGNED <u>4-24-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>April 27, 1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis</u>	
23e. FUNERAL DIRECTOR <u>BUCHHOLZ MORTUARY-5967 W. Florissant Ave</u>		23f. DATE RECD. BY LOCAL REG. <u>4-24-63</u>	
23g. REGISTRAR'S SIGNATURE <u>John Murphy, M.D.</u>		23h. REGISTRAR'S SIGNATURE <u>John Murphy, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Wilfred W. Berghol*

Licensed Embalmer No.

*4551*

P. O. Address

*St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.